GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

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SENATE BILL 388

Short Title:	Update Cervical Cancer Screening Coverage.	(Public)
Sponsors:	Senators Foxx; Allran, Apodaca, Bingham, Blake, Brock, Carpenter, Carrington, Dorsett, Forrester, Garrou, Garwood, Gulley, Hagan, Hargett, Hartsell, Horton, Jenkins, Kerr, Kinnaird, Lucas, Queen, Shubert, Sloan, Stevens, Swindell, Thomas, Tillman, and Weinstein.	
Referred to:	Health and Human Resources.	

March 12, 2003

A BILL TO BE ENTITLED

AN ACT TO UPDATE NORTH CAROLINA GENERAL STATUTES IN RESPONSE TO RECENT MEDICAL ADVANCES IN SCREENING FOR THE EARLY DETECTION OF CERVICAL CANCER.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-50-155 reads as rewritten:

"**§ 58-50-155. Standard and basic health care plan coverages.**

(a) Notwithstanding G.S. 58-50-125(c), the standard health plan developed and approved under G.S. 58-50-125 shall provide coverage for all of the following:

(1) Mammograms and ~~pap smears~~ examinations and laboratory tests for screening for the early detection of cervical cancer at least equal to the coverage required by G.S. 58-51-57.

(2) Prostate-specific antigen (PSA) tests or equivalent tests for the presence of prostate cancer at least equal to the coverage required by G.S. 58-51-58.

(3) Reconstructive breast surgery resulting from a mastectomy at least equal to the coverage required by G.S. 58-51-62.

(4) For a qualified individual, scientifically proven bone mass measurement for the diagnosis and evaluation of osteoporosis or low bone mass at least equal to the coverage required by G.S. 58-3-174.

(5) Prescribed contraceptive drugs or devices that prevent pregnancy and that are approved by the United States Food and Drug Administration for use as contraceptives, or outpatient contraceptive services at least equal to the coverage required by G.S. 58-3-178, if the plan covers prescription drugs or devices, or outpatient services, as applicable. The

same exceptions and exclusions as are provided under G.S. 58-3-178 apply to standard plans developed and approved under G.S. 58-50-125.

(6) Colorectal cancer examinations and laboratory tests at least equal to the coverage required by G.S. 58-3-179.

(a1), (a2) Repealed by Session Laws 1999-197, s. 2.

(b) Notwithstanding G.S. 58-50-125(c), in developing and approving the plans under G.S. 58-50-125, the Committee and Commissioner shall give due consideration to cost-effective and life-saving health care services and to cost-effective health care providers."

SECTION 2. G.S. 58-51-57 reads as rewritten:

"**§ 58-51-57. Coverage for mammograms and ~~pap smears.~~ cervical cancer screening.**

(a) Every policy or contract of accident or health insurance, and every preferred provider benefit plan under G.S. 58-50-56, that is issued, renewed, or amended on or after January 1, 1992, shall provide coverage for ~~pap smears~~ examinations and laboratory tests for screening for the early detection of cervical cancer and for low-dose screening mammography. The same deductibles, coinsurance, and other limitations as apply to similar services covered under the policy, contract, or plan shall apply to coverage for ~~pap smears~~ examinations and laboratory tests for screening for the early detection of cervical cancer and low-dose screening mammography.

(b) As used in this section, "low-dose screening mammography" means a radiologic procedure for the early detection of breast cancer provided to an asymptomatic woman using equipment dedicated specifically for mammography, including a physician's interpretation of the results of the procedure.

(c) Coverage for low-dose screening mammography shall be provided as follows:

(1) One or more mammograms a year, as recommended by a physician, for any woman who is at risk for breast cancer. For purposes of this subdivision, a woman is at risk for breast cancer if any one or more of the following is true:

a. The woman has a personal history of breast cancer;

b. The woman has a personal history of biopsy-proven benign breast disease;

c. The woman's mother, sister, or daughter has or has had breast cancer; or

d. The woman has not given birth prior to the age of 30;

(2) One baseline mammogram for any woman 35 through 39 years of age, inclusive;

(3) A mammogram every other year for any woman 40 through 49 years of age, inclusive, or more frequently upon recommendation of a physician; and

(4) A mammogram every year for any woman 50 years of age or older.

(d) Reimbursement for a mammogram authorized under this section shall be made only if the facility in which the mammogram was performed meets

mammography accreditation ~~standards. Mammography accreditation standards shall be those~~ standards established by the North Carolina Medical Care ~~Commission unless such standards are not in effect, in which case standards established by the United States Department of Health and Human Services for Medicare/Medicaid coverage of screening mammography shall apply until Medical Care Commission standards become effective.~~Commission. ~~Facilities that do not meet required mammography accreditation standards shall so inform the patient or the patient's legally responsible person prior to performing the mammogram.~~

(e) ~~Coverage for pap smears shall be provided for pap smears obtained once a year, or more frequently if recommended by a physician.~~ Coverage for the screening for the early detection of cervical cancer shall be in accordance with the most recently published American Cancer Society guidelines. Coverage shall include the examination, the laboratory fee, and the physician's interpretation of the laboratory results. Reimbursements for laboratory fees shall be made only if the laboratory meets accreditation standards adopted by the North Carolina Medical Care Commission.~~When the screening pap smear accreditation standards adopted by the North Carolina Medical Care Commission become effective, reimbursement for laboratory fees shall be made only if the laboratory meets those standards. Facilities utilizing services of laboratories that do not meet accreditation standards for screening pap smears shall, prior to performing the pap smear examination, inform the patient or the patient's legally responsible person that such laboratory fees will not be covered.~~"

SECTION 3. G.S. 58-65-92 reads as rewritten:

"**§ 58-65-92. Coverage for mammograms and ~~pap smears~~ cervical cancer screening.**

(a) Every insurance certificate or subscriber contract under any hospital service plan or medical service plan governed by this Article and Article 66 of this Chapter, and every preferred provider benefit plan under G.S. 58-50-56, that is issued, renewed, or amended on or after January 1, 1992, shall provide coverage for ~~pap smears~~ examinations and laboratory tests for the screening for the early detection of cervical cancer and for low-dose screening mammography. The same deductibles, coinsurance, and other limitations as apply to similar services covered under the certificate or contract shall apply to coverage for ~~pap smears~~ examinations and laboratory tests for the screening for the early detection of cervical cancer and low-dose screening mammography.

(b) As used in this section, "low-dose screening mammography" means a radiologic procedure for the early detection of breast cancer provided to an asymptomatic woman using equipment dedicated specifically for mammography, including a physician's interpretation of the results of the procedure.

(c) Coverage for low-dose screening mammography shall be provided as follows:

(1) One or more mammograms a year, as recommended by a physician, for any woman who is at risk for breast cancer. For purposes of this subdivision, a woman is at risk for breast cancer if any one or more of the following is true:

a. The woman has a personal history of breast cancer;
b. The woman has a personal history of biopsy-proven benign breast disease;
c. The woman's mother, sister, or daughter has or has had breast cancer; or
d. The woman has not given birth prior to the age of 30;

(2) One baseline mammogram for any woman 35 through 39 years of age, inclusive;

(3) A mammogram every other year for any woman 40 through 49 years of age, inclusive, or more frequently upon recommendation of a physician; and

(4) A mammogram every year for any woman 50 years of age or older.

(d) Reimbursement for a mammogram authorized under this section shall be made only if the facility in which the mammogram was performed meets mammography accreditation ~~standards. Mammography accreditation standards shall be those~~ standards established by the North Carolina Medical Care ~~Commission unless such standards are not in effect, in which case standards established by the United States Department of Health and Human Services for Medicare/Medicaid coverage of screening mammography shall apply until Medical Care Commission standards become effective.~~Commission. ~~Facilities that do not meet required mammography accreditation standards shall so inform the patient or the patient's legally responsible person prior to performing the mammogram.~~

(e) ~~Coverage for pap smears shall be provided for pap smears obtained once a year, or more frequently if recommended by a physician.~~ Coverage for the screening for the early detection of cervical cancer shall be in accordance with the most recently published American Cancer Society guidelines. Coverage shall include the examination, the laboratory fee, and the physician's interpretation of the laboratory results. Reimbursements for laboratory fees shall be made only if the laboratory meets accreditation standards adopted by the North Carolina Medical Care Commission.~~When the screening pap smear accreditation standards adopted by the North Carolina Medical Care Commission become effective, reimbursement for laboratory fees shall be made only if the laboratory meets those standards. Facilities utilizing services of laboratories that do not meet accreditation standards for screening pap smears shall, prior to performing the pap smear examination, inform the patient or the patient's legally responsible person that such laboratory fees will not be covered.~~"

SECTION 3. G.S. 59-67-76 reads as rewritten:

(a) Every health care plan written by a health maintenance organization and in force, issued, renewed, or amended on or after January 1, 1992, that is subject to this Article, shall provide coverage for ~~pap smears~~ examinations and laboratory tests for the screening for the early detection of cervical cancer and for low-dose screening mammography. The same deductibles, coinsurance, and other limitations as apply to similar services covered under the plan shall apply to coverage for ~~pap smears~~ examinations and laboratory tests for the screening for the early detection of cervical cancer and low-dose screening mammography.

(b) As used in this section, "low-dose screening mammography" means a radiologic procedure for the early detection of breast cancer provided to an asymptomatic woman using equipment dedicated specifically for mammography, including a physician's interpretation of the results of the procedure.

(c) Coverage for low-dose screening mammography shall be provided as follows:

(1) One or more mammograms a year, as recommended by a physician, for any woman who is determined to be at risk for breast cancer. For purposes of this subdivision, a woman is at risk for breast cancer if any one or more of the following is true:

a. The woman has a personal history of breast cancer;

b. The woman has a personal history of biopsy-proven benign breast disease;

c. The woman's mother, sister, or daughter has or has had breast cancer; or

d. The woman has not given birth prior to the age of 30;

(2) One baseline mammogram for any woman 35 through 39 years of age, inclusive;

(3) A mammogram every other year for any woman 40 through 49 years of age, inclusive, or more frequently upon recommendation of a physician; and

(4) A mammogram every year for any woman 50 years of age or older.

(d) Reimbursement for a mammogram authorized under this section shall be made only if the facility in which the mammogram was performed meets mammography accreditation ~~standards. Mammography accreditation standards shall be those~~ standards established by the North Carolina Medical Care ~~Commission unless such standards are not in effect, in which case standards established by the United States Department of Health and Human Services for Medicare/Medicaid coverage of screening mammography shall apply until Medical Care Commission standards become effective.~~Commission. ~~Facilities that do not meet required mammography accreditation standards shall so inform the patient or the patient's legally responsible person prior to performing the mammogram.~~

(e) ~~Coverage for pap smears shall be provided for pap smears obtained once a year, or more frequently if recommended by a physician.~~ Coverage for the screening for the early detection of cervical cancer shall be in accordance with the most recently published American Cancer Society guidelines. Coverage shall include the examination, the laboratory fee, and the physician's interpretation of the laboratory results. Reimbursements for laboratory fees shall be made only if the laboratory meets accreditation standards adopted by the North Carolina Medical Care Commission.~~When the screening pap smear accreditation standards adopted by the North Carolina Medical Care Commission become effective, reimbursement for laboratory fees shall be made only if the laboratory meets those standards. Facilities utilizing services of laboratories that do not meet accreditation standards for screening pap smears shall, prior to~~

~~performing the pap smear examination, inform the patient or the patient's legally responsible person that such laboratory fees will not be covered.~~"

SECTION 4. G.S. 135-40.5(e) reads as rewritten:

"(e) Routine Diagnostic Examinations. – The Plan will pay one hundred percent (100%) of allowable charges for routine diagnostic examinations and tests, including breast, colon, rectal, and prostate exams, X rays, mammograms, blood and blood pressure checks, urine tests, tuberculosis tests, and general health checkups that are medically necessary for the maintenance and improvement of individual health but no more often than once every three years for covered individuals to age 40 years, once every two years for covered individuals to age 50 years, and once a year for covered individuals age 50 years and older, unless a more frequent occurrence is warranted by a medical condition when such charges are incurred in a medically supervised facility. Routine diagnostic examinations and tests covered under this subsection also include ~~one Pap smear per year~~ examinations and tests for the screening for the early detection of cervical cancer. The coverage shall be in accordance with the most recently published American Cancer Society guidelines for any covered female. Provided, however, that charges for such examinations and tests are not covered by the Plan when they are incurred to obtain or continue employment, to secure insurance coverage, to comply with legal proceedings, to attend schools or camps, to meet travel requirements, to participate in athletic and related activities, or to comply with governmental licensing requirements. The maximum amount payable under this subsection for a covered individual is one hundred fifty dollars ($150.00) per fiscal year."

SECTION 5. This act becomes effective January 1, 2004, and applies to all health benefit plans that are delivered, issued for delivery, or renewed on and after that date. For the purposes of this act, renewal of a health benefit plan is presumed to occur on each anniversary of the date on which coverage was first effective on the person or persons covered by the health benefit plan.